Washington State Health Care Authority

Report to the Legislature

SmartHealth Effectiveness
2nd Quarterly Report

Second Engrossed Substitute House Bill 2376,
Subsection 213 (2)(b)(i)
Chapter 36, Laws of 2016, 1st Extraordinary Session

September 30, 2016

Washington State
Health Care Authority

Public Employees Benefits Board
PO Box 42684
Olympia, WA 98504-2684
Phone: (360) 725-0440
Fax: (360) 725-0771

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EXECUTIVE SUMMARY

This report is an evaluation of the effectiveness of SmartHealth—an employee wellness program that includes an online portal launched in January 2015 as a way for PEBB program members to improve their health and well-being. Eligible employees can use the portal to register for SmartHealth, complete a well-being assessment, and participate in enough of the program's health and wellness activities to earn at least 2,000 points. Those that earn 2,000 points receive a $125 discount on their medical deductible in the following calendar year.

In 2016, E2SHB 2376, Subsection 213 (2)(b)(i) directed the Health Care Authority (HCA) to evaluate the effectiveness of the SmartHealth program on a quarterly basis, with the first report to the Legislature due on June 30, 2016. HCA worked collaboratively with the Office of Financial Management (OFM), the Washington State Institute for Public Policy (WSIPP), and Limeade (the SmartHealth portal vendor) to create a data analysis team to determine the metrics for the evaluation and conduct the evaluation.

This is the second report of the effectiveness of the SmartHealth program. It covers the first two quarters of calendar year (CY) 2016, and provides data from the 2015 baseline period that appeared in the last report. Additional metrics on employee wellness and cost-effectiveness will be included in future reports.

Because the incentive period for 2016 ends on September 30, 2016, the same date that this report is being issued, it does not include a year to year comparison of SmartHealth data. We anticipate being able to provide a preliminary analysis of 2015 vs. 2016 in the third report which is due on December 30, 2016. The final analysis of the first two years of the program will be provided in the report that is due on March 30, 2017.

The focus of this report is to provide a more thorough discussion of some of the information provided in the first report, offer additional information related to chronic disease management, and report on the efficacy of specific outreach activities on enrollment and participation, and the impact on dental preventive visits.

The first report included a literature review of the effectiveness of worksite wellness programs and a history of the SmartHealth program. Rather than repeat this review, we encourage the reader to read the Report to the Legislature on SmartHealth Effectiveness (June 30, 2016) which is available on the HCA website.

SMARTHEALTH COMMUNICATION STRATEGIES

OVERVIEW

The first year (Calendar Year 2015) of operation of the SmartHealth program focused on optimizing program design, collecting baseline data, gaining an understanding of population profiles, identifying needs and interests, and keying in on what communication methods best drive registration and program engagement.

Monthly emails were sent to members who registered with SmartHealth. Figure 1 shows the "open rate" for these monthly emails. The open rate refers to the unique count of email recipients who opened the email. (The open count is calculated from a recipient downloading a hidden image in the email. If the recipient's default email setting blocks images but they opened the email, they will not be added to the unique open count.)

The average open rate for Limeade's book of business is 25% per email.

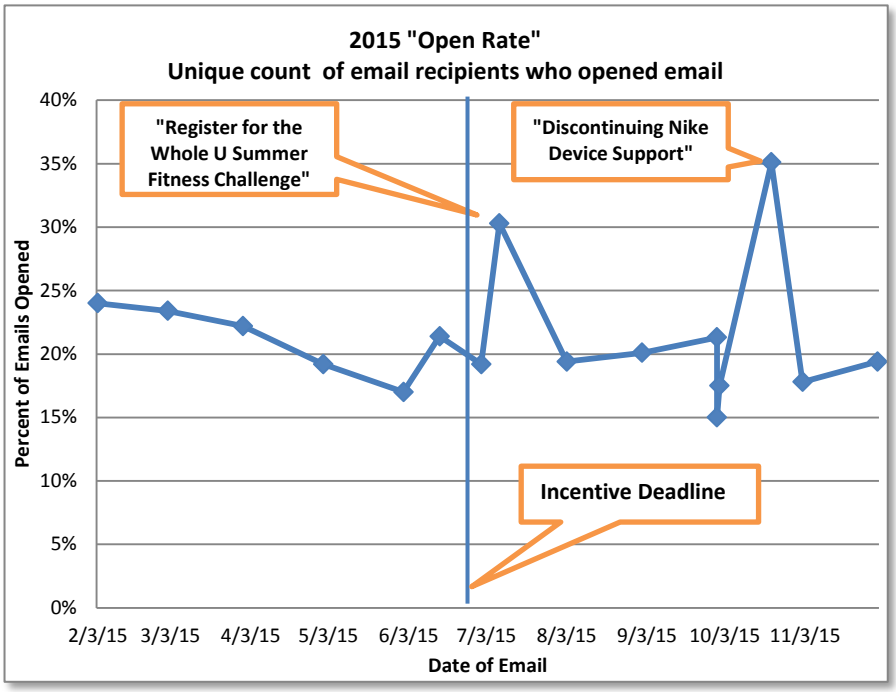

FIGURE 1: 2015 "OPEN RATE" – UNIQUE COUNT OF EMAIL RECIPIENTS WHO OPENED EMAILS

The “click rate” refers to the unique count of email recipients who clicked on any link in the email message. The average click rate for Limeade’s book of business is approximately 6% per email. The click rate for SmartHealth emails was higher than that for most of the year, even after the incentive earning period ended on June 30, 2015. We continue to analyze the most effective subject lines in order to improve email open and click rates.

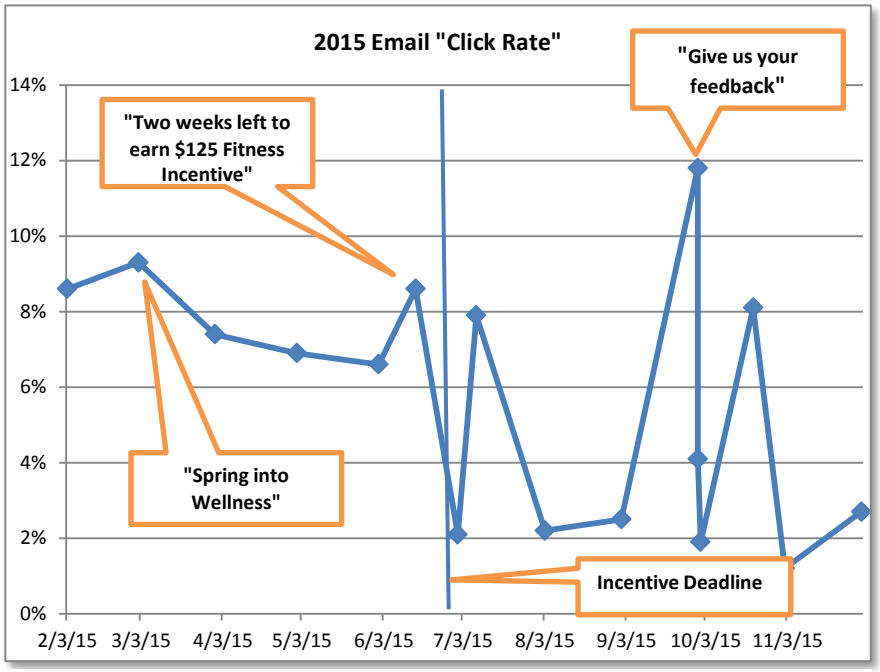

FIGURE 2: 2015 EMAIL “CLICK RATE”

INSIGHTS AND ACTIONS

When communicating to a mass audience by email, HCA has found that the best subject lines clearly explain what's inside the email and indicate the value to the reader. Because subject lines drive open rate, it’s important to write clear and direct subject lines to keep the open rate high. For example:

- *Renew. Restart. Refresh with SmartHealth.* (Open rate = 32%)
- *Are you ready to share your success?* (Open rate = 18%)

Shorter subject lines tend to have better open rates. When the subject lines are shorter, the open rate tends to be higher. We will continue to use short (but clear) subject lines to keep the click rate high. For example:

- *Stay on track with your 2015 resolutions* (open rate = 24%)

- *Hurry! Your chance to earn a $125 wellness incentive ends June 30, 2015 (open rate = 17%)*

Rewards tend to generate higher click rates. There may be other variables that drive up click rates but SmartHealth emails that had higher click rates mentioned rewards in the subject lines. These rewards could be anything from extra bonus points, financial incentives, improved well-being or giveaways such as Seahawks tickets.

Figure 3 shows the positive impact on engagement associated with various promotions during 2016. Promotions related to rewards that had deadlines tended to drive higher engagement among SmartHealth-eligible participants.

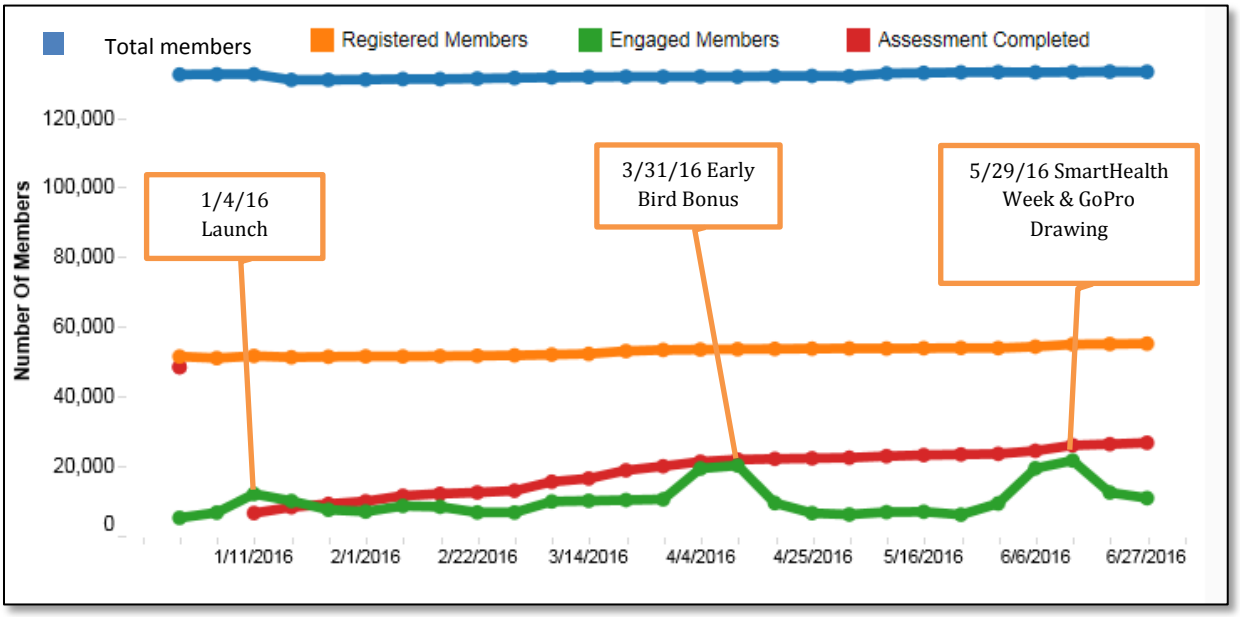

FIGURE 3: IMPACT OF 2016 PROMOTIONS ON SMARTHEALTH-ELIGIBLE MEMBER ENGAGEMENT

Promotional campaigns are also effective at getting participants re-engaged with the platform as shown in Figure 4. The Early Bird bonus in March 2016 provided additional points to participants engaging in their first activity: this resulted in an additional 9,000 SmartHealth eligible members participating in their first activity. SmartHealth Week, in June, encouraged an additional 8,500 members to participate in their first activity through the SmartHealth platform.

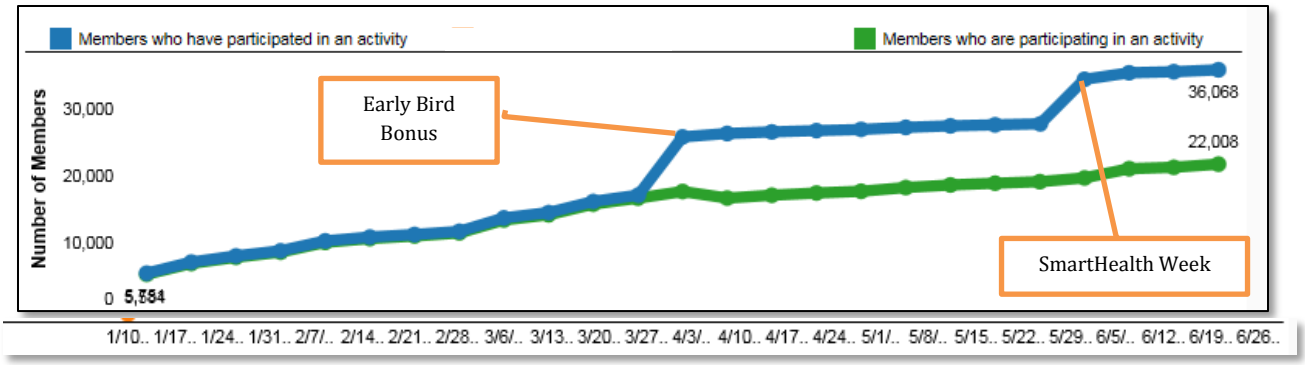

FIGURE 4: IMPACT OF 2016 PROMOTIONS ON ENGAGEMENT IN FIRST ACTIVITY

2016 Partial Year Report Metrics

The online version of the SmartHealth program has been operative for six quarters, however, as of this date, only one full year of data is available—the baseline year of 2015. For 2016, the second year of the program, two quarters of data are available for analysis within this report. Relevant metrics at this stage of the program focus on participation rates, health status of participants, the top interventions, and participation by work organization.

While we are providing results for the first two quarters of 2016, we caution against drawing conclusions on 2016 program effectiveness until the December 30, 2016 report due to the fact that the incentive period has not yet ended. Participants in 2015 had until June 30th to complete the requirements, while participants in 2016 have until September 30th. What we found in the baseline year was that participants increased their activities as the June 30th incentive qualification deadline approached, and then participation dropped off sharply. In 2016, we anticipate a similar increase in activity as the September 30th deadline approaches. However, as the 2016 deadline coincides with the publication of this report, HCA is unable to report on the trend for 2016 until the end of the year.

Participation

As shown in Figure 5, by June 30, 2016, 42% of SmartHealth-eligible members had registered for the SmartHealth program. 49% of those registered had completed their well-being assessment and 27% of those registered had already completed enough activities to earn an incentive.

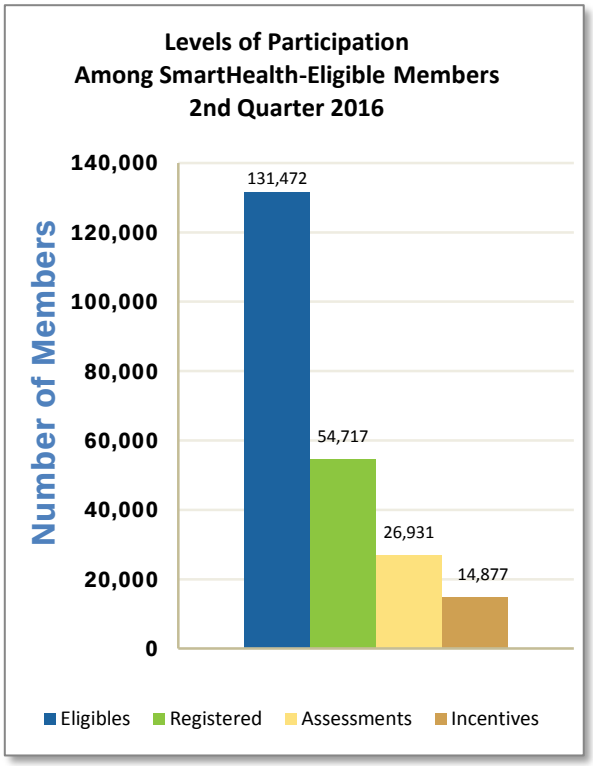

FIGURE 5: LEVELS OF PARTICIPATION AMONG SMARTHEALTH-ELIGIBLE MEMBERS – 2ND QUARTER 2016

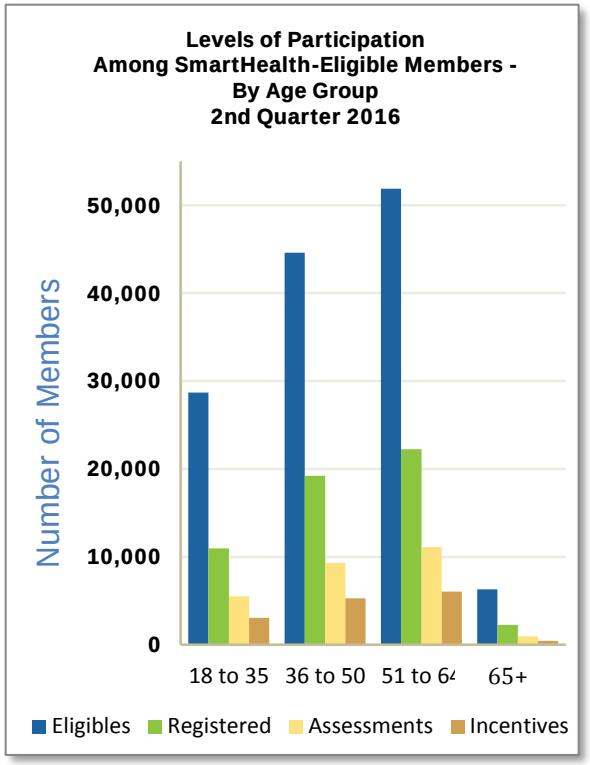

FIGURE 6: LEVELS OF PARTICIPATION BY AGE GROUP – 2ND QUARTER 2016

Figure 6 shows the rate of participation for different age cohorts. The average rate of participation for two age groups 36 to 50 and 51 to 64 was 21% (as measured by the percentage of eligible members who completed their well-being assessments). The rate of participation for the 18 to 35 year old age group was slightly lower at 19%. The lowest level of participation was for those in the age group 65 and over, 15% of whom completed their well-being assessments by June 30, 2016.

Figure 7 shows the level of participation broken out by females and males. Of SmartHealth-eligible members, women outnumber men 56% to 44%. In the first half of 2016, women participated at a much higher rate than men; 25% of eligible women completed their well-being assessment as of June 30, 2016 compared to 15% of eligible men.

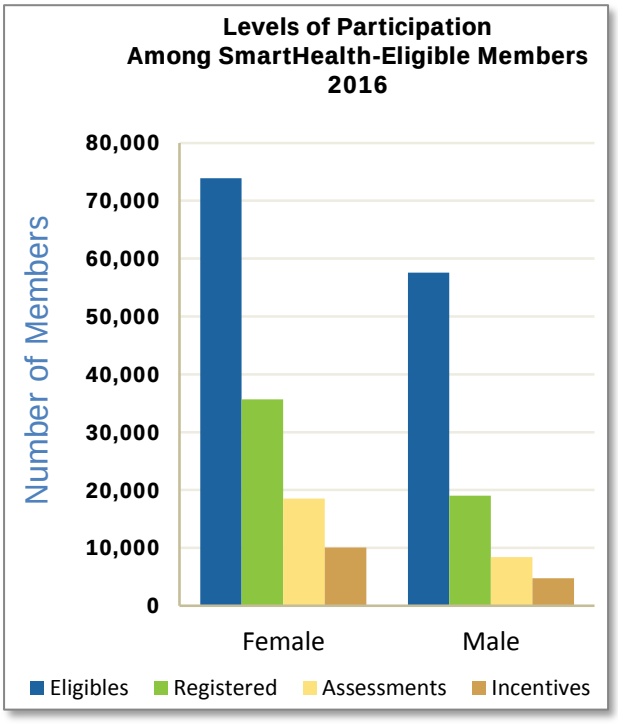

FIGURE 7: LEVELS OF PARTICIPATION BY GENDER – 2ND QUARTER 2016

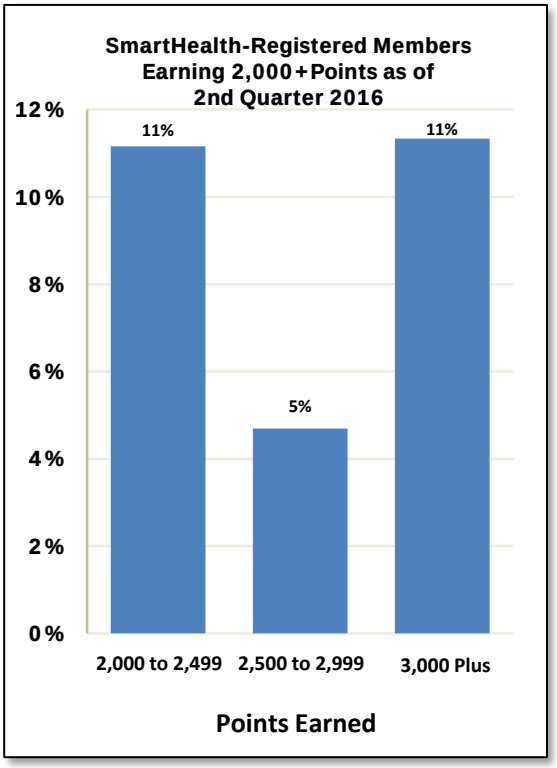

FIGURE 8: REGISTERED ENROLLEES EARNING 2000 OR MORE POINTS AS OF 2ND QUARTER 2016

Figure 8 shows the percentage of SmartHealth-registered members by the level of points achieved in the program. As of June 30, 2016, 27% of SmartHealth-registered members had earned at least 2,000 points and qualified for the incentive with most of those continuing to participate in activities and earning points beyond the minimum requirement.

Figure 9 shows the percentage of participants earning an incentive by June 30, broken out by different cohorts. Of those who have already earned the incentive, those within the 18 to 35 age group are well represented as are women and SmartHealth-eligible members employed by agencies.

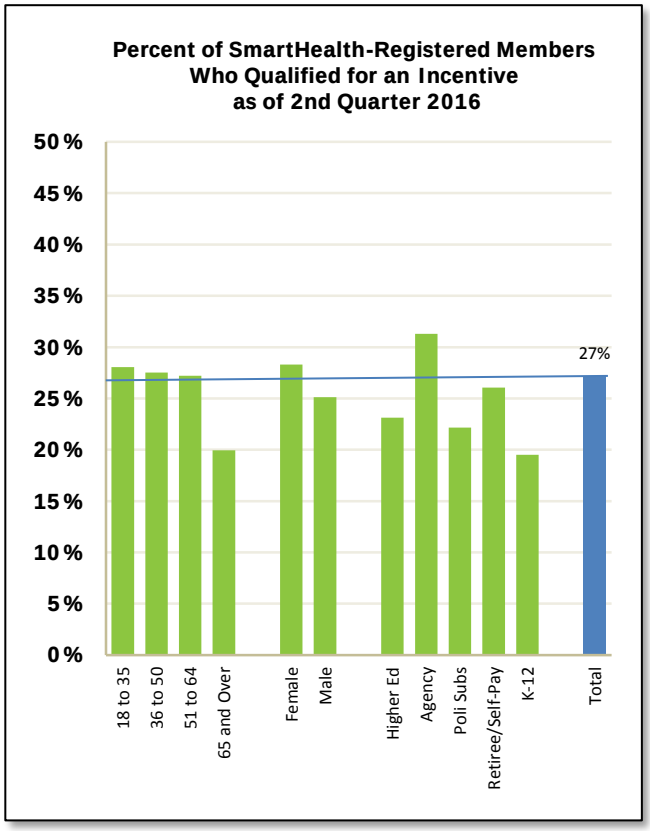

FIGURE 9: PERCENT WHO QUALIFIED FOR AN INCENTIVE AS OF 2ND QUARTER 2016

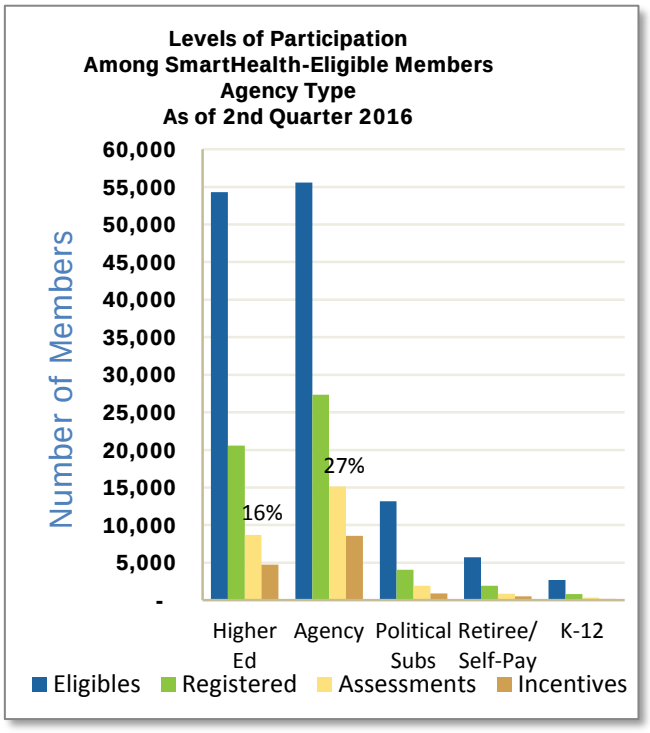

FIGURE 10: PARTICIPATION BY AGENCY TYPE – 2ND QUARTER 2016

As shown in Figure 10, by the end of the second quarter in 2016, SmartHealth-eligible members within agencies are participating at a much higher rate (27%), than those within the Higher Education organizations (16%), as measured by completion of the well-being assessment. Several factors explain the gap between higher education and agency participation:

- The SmartHealth team at HCA has longer established relationships with agencies than with the higher education institutions.

- Both the University of Washington and Washington State University together comprise 67% of the higher education SmartHealth eligible population and registration at these institutions has historically been relatively low (see Appendix II for the breakdown of totals by agency/higher education). Many higher education employees are not PEBB benefits-eligible and therefore are unable to participate in the SmartHealth wellness portal, creating a challenge for Wellness Coordinators at the University of Washington and Washington State University to fully incorporate this tool into their wellness programs. The SmartHealth team and Limeade is in the process of finding a solution to this issue.

- Most higher education institutions operate on a school-year calendar, which runs from the beginning of September until the end of June, with many higher education employees off of work over the summer months. In contrast, the SmartHealth incentive program runs from January until the end of September (until June 30 in the baseline year). Keeping the higher education members engaged over the summer months, a time when many SmartHealth members become more engaged in physical activities and continue to earn points, can be a challenge. Nevertheless, the SmartHealth team has recently engaged with these two institutions to develop promotions that align with their employees' work schedules and their cultures and encourage member engagement.

HEALTH STATUS

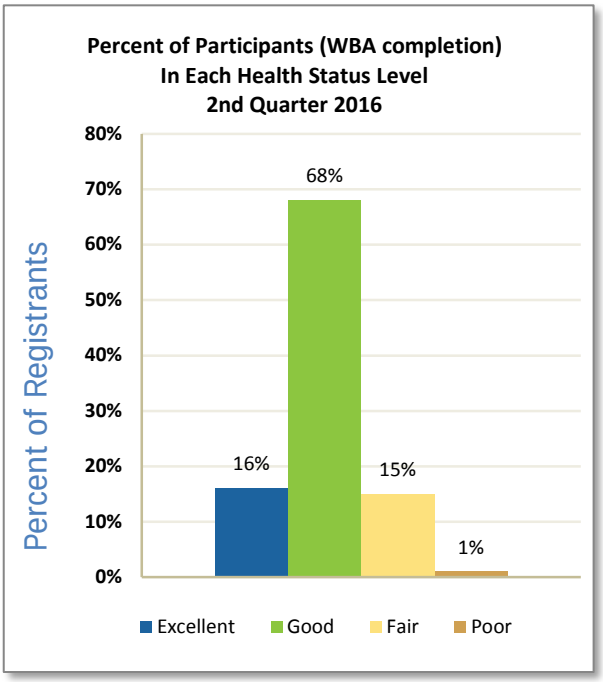

FIGURE 11: PERCENT OF PARTICIPANTS IN EACH HEALTH STATUS LEVEL – 2ND QUARTER 2016

Figure 11 shows the self-assessed health status of SmartHealth program participants. Participants who complete their well-being assessments (WBA) are asked to self-report their health status level within one of four categories: excellent, good, fair or poor. Half way through this year 68% of SmartHealth participants had assessed their own health status as "good" with 16% rating their own health as "excellent". Only 1% rated their health status as "poor".

The ten risk components captured by the SmartHealth WBA are: Healthy Weight, Back Health, Sleep, Exercise and Fitness, Drinking Moderately, Health Blood Sugar, Nutrition, Smoke Free Living, Heart Health and Self Care. Figure 12 shows how many of the participants had 0, 1, 2, or 3 or more of these ten risks based on their answers to the well-being assessment. 72% of the population measured reported either zero or just one health risk. Compared to the Limeade book of business, the SmartHealth population had better scores for Smoke Free Living, Self-Care and Healthy Weight. The SmartHealth population scored worse than Limeade's book of business for the other seven risk factors.

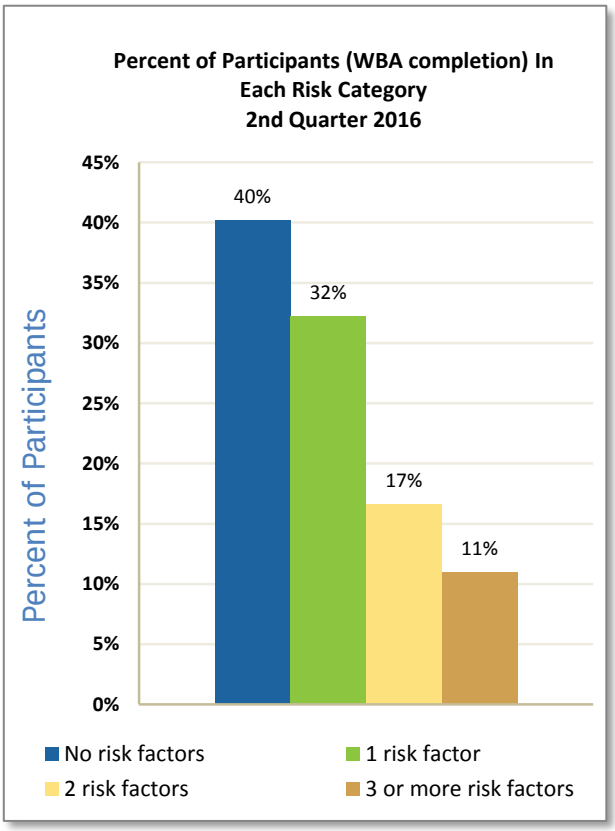

FIGURE 12: PERCENT OF PARTICIPANTS IN EACH RISK CATEGORY – 2ND QUARTER 2016

DENTAL

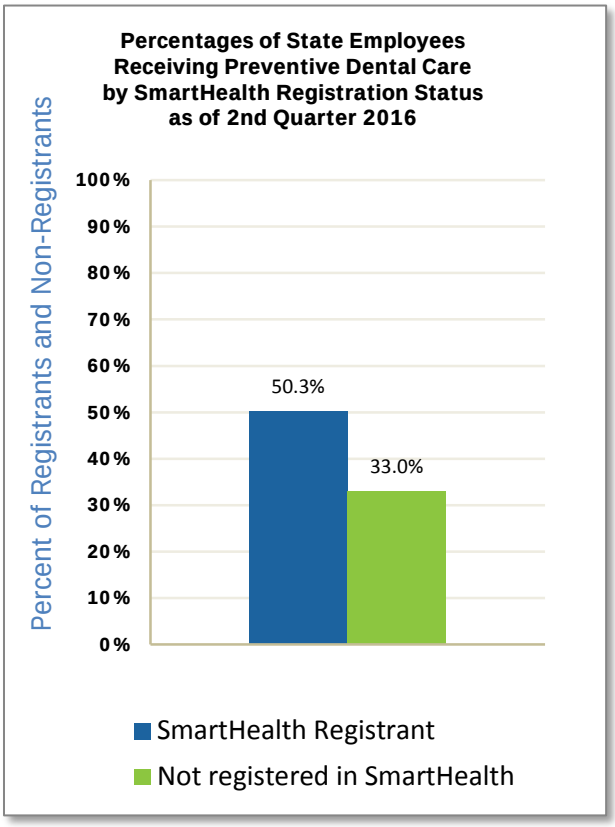

FIGURE 13: PERCENTAGES RECEIVING PREVENTIVE DENTAL CARE EXAM – AS OF 2ND QUARTER 2016

Previous data from the PEBB Dental Plans showed a low percentage of members receiving preventive dental care exams. In 2016 the SmartHealth program promoted preventive dental exams by posting an activity that provided points for getting an exam, which was then verified by claims data. In the first two quarters of 2016 more than 50% of SmartHealth-registered enrollees had received a preventive dental care exam, compared with only 33% for the cohort that was not registered in SmartHealth, as shown in Figure 13. The percentage of members receiving dental care from year to year tends to remain stable so the increase observed in the SmartHealth cohort constitutes a dramatic change and may be driven by the introduction of the SmartHealth program. Nevertheless, it is important to point out that this data is correlative only; causality cannot be proved.

HEALTH RISKS AND ACTIVITY DEVELOPMENT

The top five risk components captured by the SmartHealth WBA in 2015 and through June 30, 2016 are Healthy Weight, Back Health, Sleep, Exercise and Nutrition. The SmartHealth program design in 2016 focuses on promoting activities related to these risk components. Figure 14 (next page) shows SmartHealth enrollee participation in each of these types of activities in the first half of 2016.

- Although Healthy Weight is the most frequent risk component, no single weight management program has been shown to produce sustainable body fat loss across a population. Healthy food consumption and consistent participation in both movement and strength building are essential components for improving health through weight management. There is increasing evidence that sleep issues may also play a significant role in weight management.

- Multiple factors are involved in attaining and maintaining back health—weight management, movement, strength, flexibility and proper posture while sitting and standing are all important.

Activities available to SmartHealth participants January through June 2016 were grouped by the Eat, Move and Sleep themes as shown in Figure 14. Participation numbers are provided below.

  - Eat: Seven activities with 47,253 participants
  - Move: Twelve activities with 64,969 participants.
  - Sleep: Four activities with 32,438 participants

FIGURE 14: ACTIVITY PARTICIPATION BY CATEGORY – AS OF 2ND QUARTER 2016

CONDITION MANAGEMENT

DIABETES PREVENTION PROGRAM PARTICIPATION

The Diabetes Prevention Program (DPP) screening test (A1c) and classes are offered to PEBB-insured members at the worksite. This worksite model has proven very effective in terms of employee engagement, producing both high enrollment and completion rates. SmartHealth is used to promote the DPP, but participation is dependent on the availability of worksite-based classes. The majority of participation occurs at the worksite. As of the date of this report, 914 members have tested within the prediabetes range (A1C) and 829 (91%) have enrolled in classes.

TOBACCO CESSATION

Tobacco cessation is available to all SmartHealth-eligible members. WBA data through June 30, 2016 indicates a 3% tobacco use rate among SmartHealth members. 152 people have started a Tobacco Cessation program.

CHRONIC DISEASE SELF-MANAGEMENT PROGRAM PARTICIPATION

The Living Well Workshop (Chronic Disease Self-Management) is an evidence-based program available to Group Health members with a chronic condition. The workshop (consisting of six two-hour sessions) focuses on improved management of the person's chronic conditions. 155 people completed the workshop in 2015 and 24 people completed the workshop in the first half of 2016.

FUTURE PLANS AND NEXT STEPS

In the course of developing these first two reports, the data team identified a number of effectiveness measures and plans are already underway for gathering and reporting on additional metrics for future reports. HCA is working with its partners to identify an approach for assessing and reporting on cost-effectiveness, and determining timing and resource needs.

The following is an overview of these plans:

- Year One (2015): During the first year, the main goal was to collect baseline data, commence health and well-being engagement activities, and optimize program design.
- Year Two (2016): During the second year (in progress), the focus has shifted to understanding subpopulation profiles, what their needs and interests are, and how to engage them more through the portal and through a tighter connection with their organizational leaders.
- Year Three (2017): By the end of the third year there may be enough data to start examining initial outcomes and charting trends in behavior and risk profiles which can be used to guide further program modifications.
- Fourth and fifth years (2018 – 2019): After three years most wellness program designs allow for a comprehensive program value analysis. Changes in behavior and risk are evaluated and trends are examined.

For the final quarterly proviso report to the Legislature, to be completed on June 30, 2017, HCA will be able to show a comparison of the program for 2015, 2016 and the first quarter of 2017. In the future the data team recommends providing annual reports in order to include a full year of experience in each report and conduct year-to-year comparisons. Being able to compare the SmartHealth participant cohort with the non-SmartHealth cohort will require a more extensive analysis, most likely by a third party. This will entail linking Limeade program data with PEBB program medical and pharmaceutical claims data, information regarding employees' paid time off, vacation, sick time usage, turnover/tenure, workers compensation/disability claims, and employee engagement surveys.

Having a third party conduct this analysis would ensure independence and objectivity in the analyses as well as guarantee compliance with privacy and legal requirements. This analysis would entail linking data on eligibility, the well-being assessments, productivity and claims (for example) for the participant cohort and comparing it with the non-participant cohort. This would allow for an evaluation of comparative outcomes for the two cohorts in areas such as productivity and sick leave usage, biometric data (currently self-reported, not collected through onsite screening or directly from lab), health improvement among people at risk, engagement of general and at-risk populations in wellness activities, utilization of medical services by participants vs. non-

participants around total cost, preventive visits, preventable emergency room visits, etc., and benefits of preventive screenings (such as percentages of employees diagnosed with colon cancer after a colonoscopy). Additional resources would be required to conduct this type of sophisticated, statistical analysis of cost-effectiveness.

2017 Program Plans

In 2016 HCA engaged a marketing firm to analyze program data on participation and develop a marketing and promotions plan for 2016 and 2017. The 2017 plan is still being refined and will be provided to the State Health and Wellness Steering Committee for their input at their September 2016 meeting, with implementation beginning in December 2016. The following are some highlights of the proposed plan:

- High-level goals for 2017: Attract members attention and direct them to take action; Keep healthy people healthy, move less healthy people down one risk factor; get more members registered and keep them interested; and give members a reason to move beyond Level 1 (2000 points – the $125 incentive level).

- High-level strategies for 2017: Increase participation at both the individual and organizational levels; redefine the levels and points structure to create meaningful distinctions and rewards for the different levels; build on the rewards-oriented challenges that worked in 2015 and 2016 and incorporate new challenges into the mix; and use communications methods that will reach more people and have them take action more frequently.

Incentive Design

As shown in the previous report, providing a financial incentive to encourage participation in worksite wellness programs has a positive impact on participation. Providing rewards for participation at different levels can encourage continued engagement. Currently, the program is structured to provide a $125 financial incentive to members who register for SmartHealth, complete a well-being assessment, and participate in enough activities to earn at least 2,000 points to achieve Level 1. The data shows that many participants end their engagement with the platform after achieving Level 1, while a significant number of participants go on to earn 3,000 points and beyond. To encourage continued engagement with the platform and with wellness activities we propose revising the point levels and providing rewards at three different levels of achievement:

Level 1: 2,000 points ($125 incentive earned). No change.

Level 2: 3,500 points (possible drawings and rewards for achieving)

Level 3: 5,000 points (possible additional drawings and rewards for achieving).

For 2018 the opportunity exists to change the Level 1 incentive by either increasing the incentive, or changing the way it is delivered. For example, it could be delivered during the year in which it is earned through some other mechanism besides a discount off of the member's deductible. This is limited, in part, by the state collective bargaining agreement; calendar year 2020 is likely to be the earliest time that some of these changes could occur.

APPENDIX I

2015 BASELINE DATA

The first Legislative Report, dated June 30, 2016, provided the 2015 baseline data for the SmartHealth program. We are including a number of the charts from 2015 data for reference purposes, but encourage readers to review the full report and analysis from the baseline year on the HCA website.

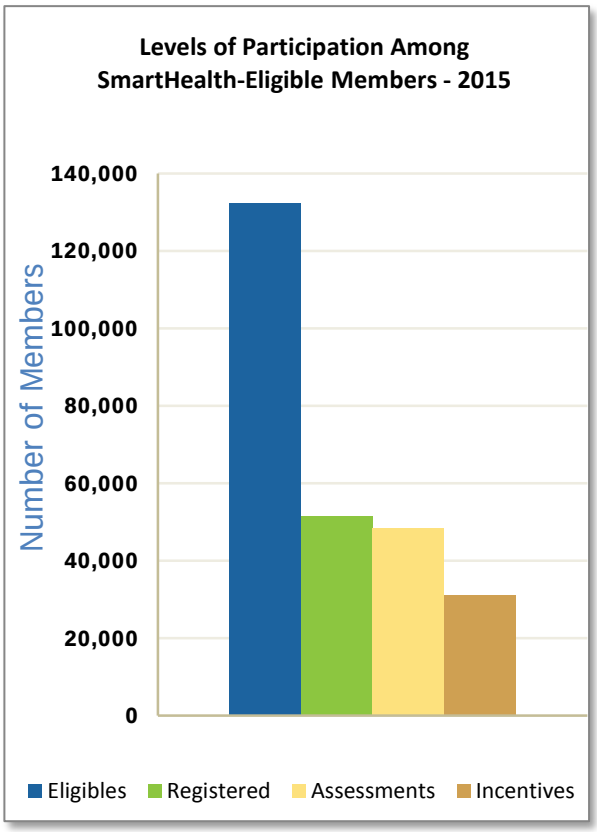

FIGURE 15: LEVELS OF PARTICIPATION AMONG SMARTHEALTH-ELIGIBLE MEMBERS - 2015

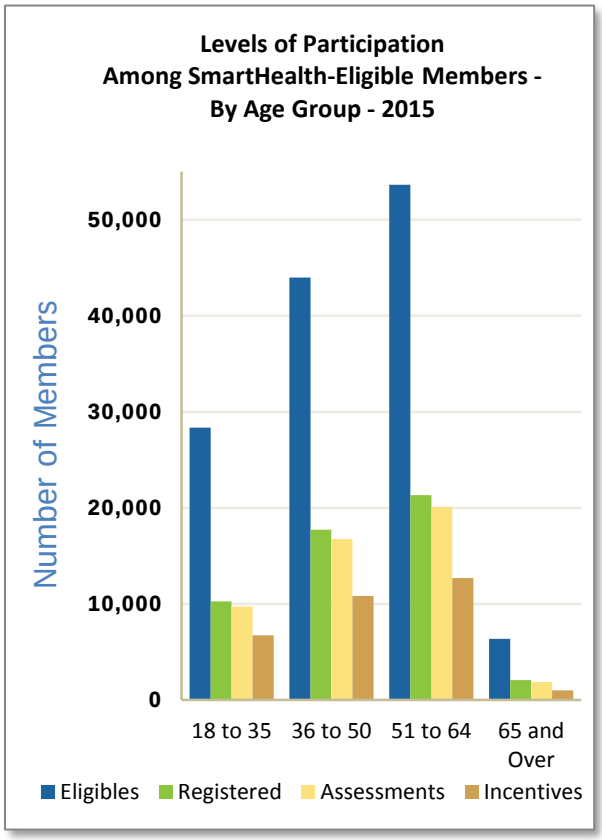

FIGURE 16: LEVELS OF PARTICIPATION AMONG SMARTHEALTH-ELIGIBLE MEMBERS – BY AGE GROUP - 2015

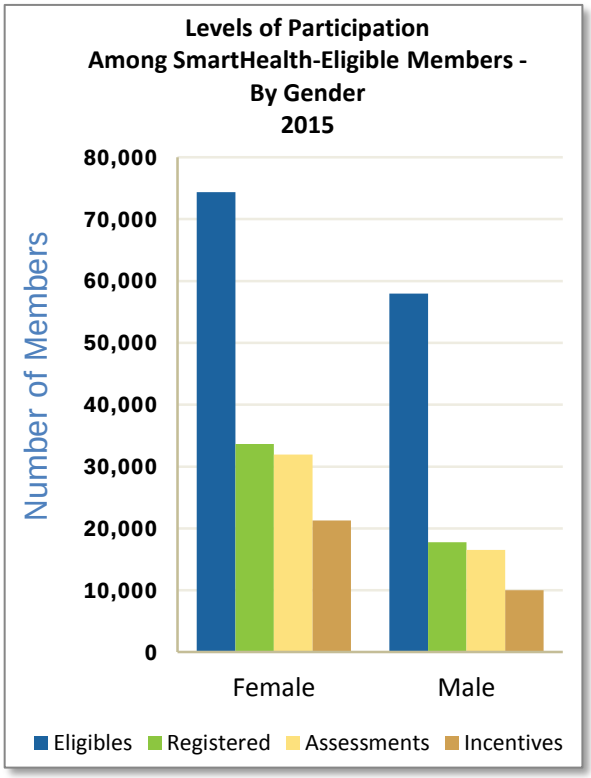

FIGURE 17: LEVELS OF PARTICIPATION AMONG SMARTHEALTH-ELIGIBLE MEMBERS – BY GENDER - 2015

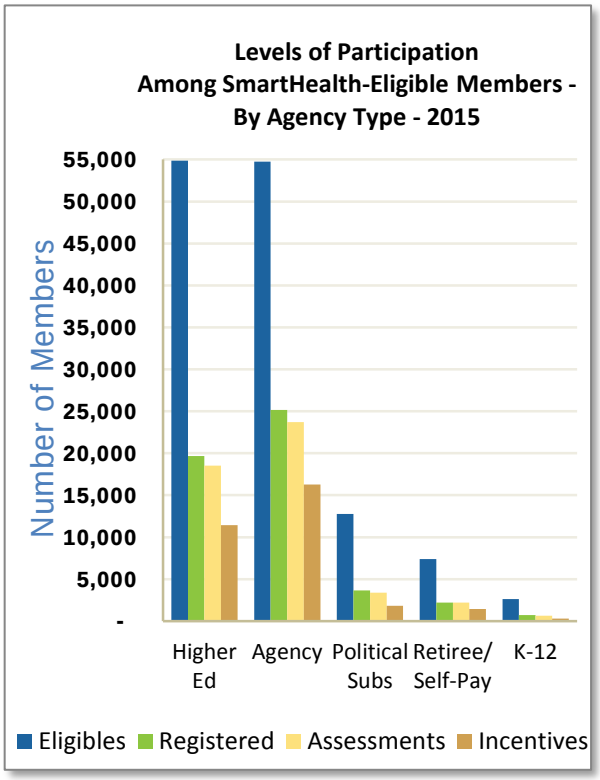

FIGURE 18: LEVELS OF PARTICIPATION AMONG SMARTHEALTH- ELIGIBLE MEMBERS – BY AGENCY TYPE - 2015

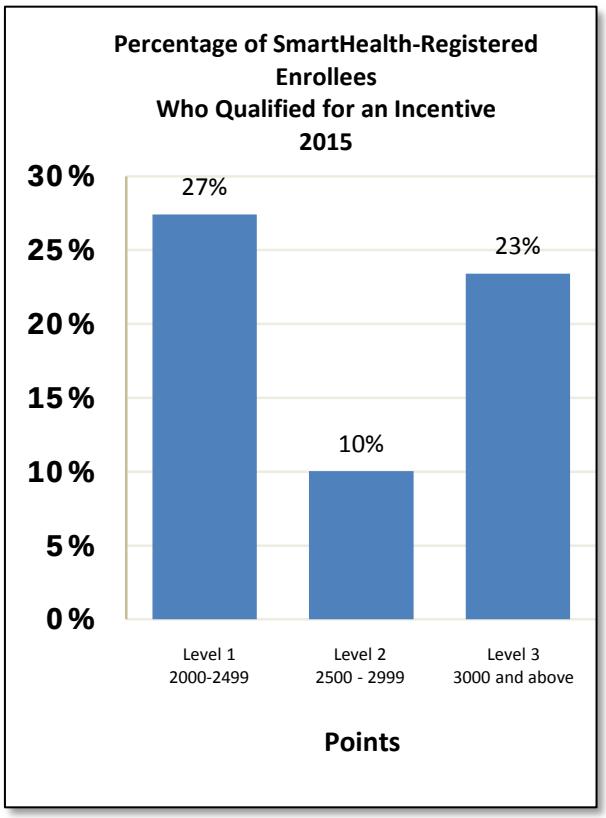

FIGURE 19: PERCENTAGE OF SMARTHEALTH-REGISTERED ENROLLEES WHO EARNED AN INCENTIVE - 2015

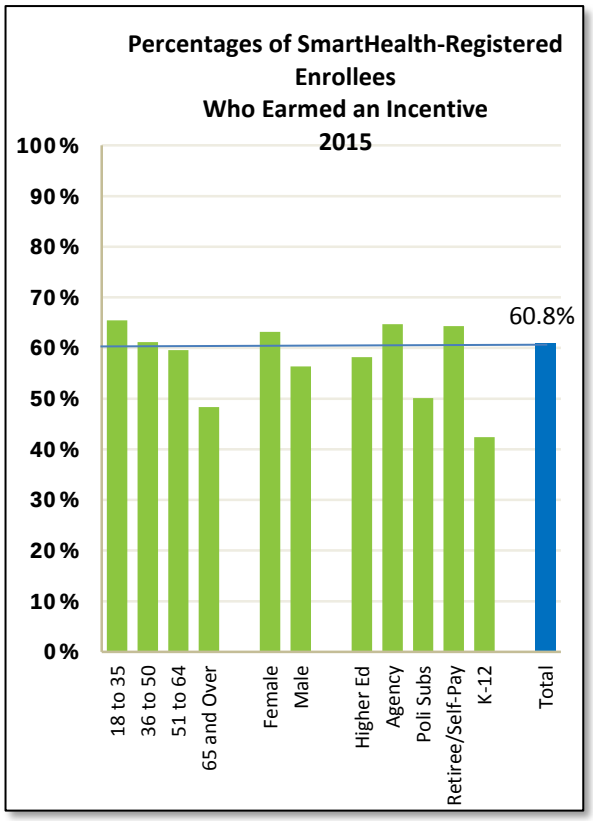

FIGURE 20: PERCENTAGES OF SMARTHEALTH-REGISTERED ENROLLEES WHO EARNED AN INCENTIVE - 2015

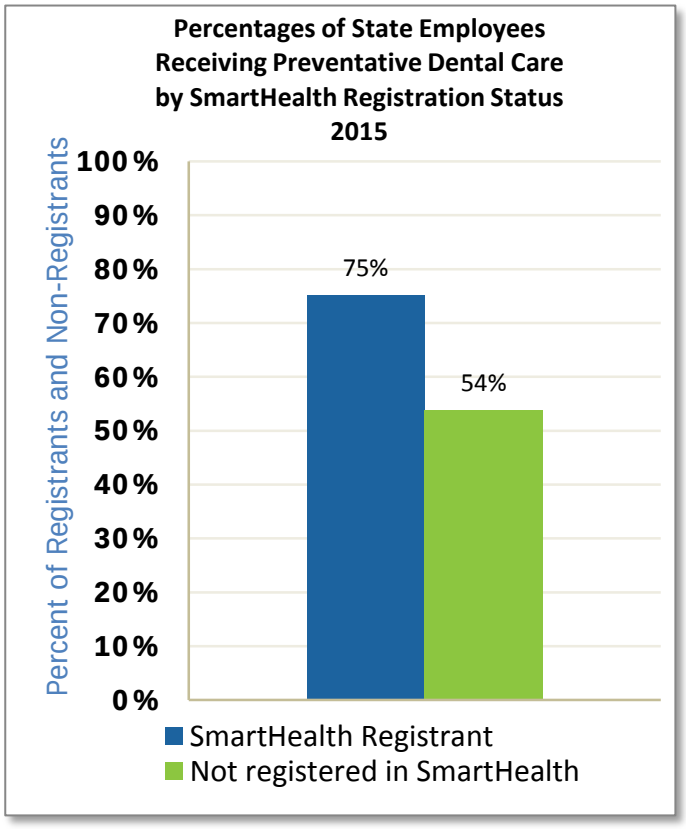

FIGURE 21: PERCENTAGES RECEIVING PREVENTIVE DENTAL CARE EXAM - 2015

APPENDIX II

PERCENT ASSESSMENT COMPLETION BY AGENCY – JANUARY THROUGH JUNE 2016
(next page)

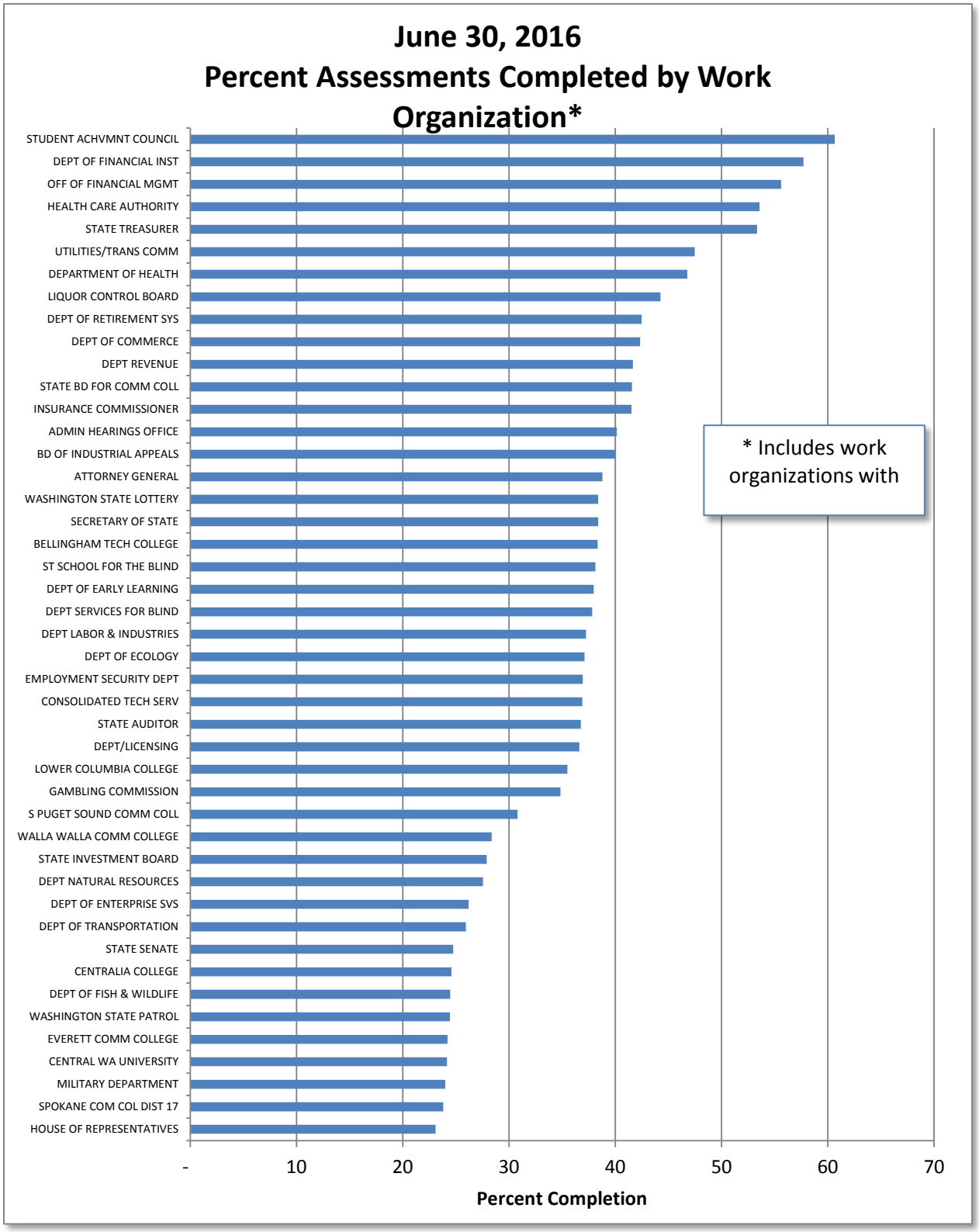

FIGURE 22: PARTICIPATION BY AGENCY, DETAILED – 2ND QUARTER 2016 (PART ONE)

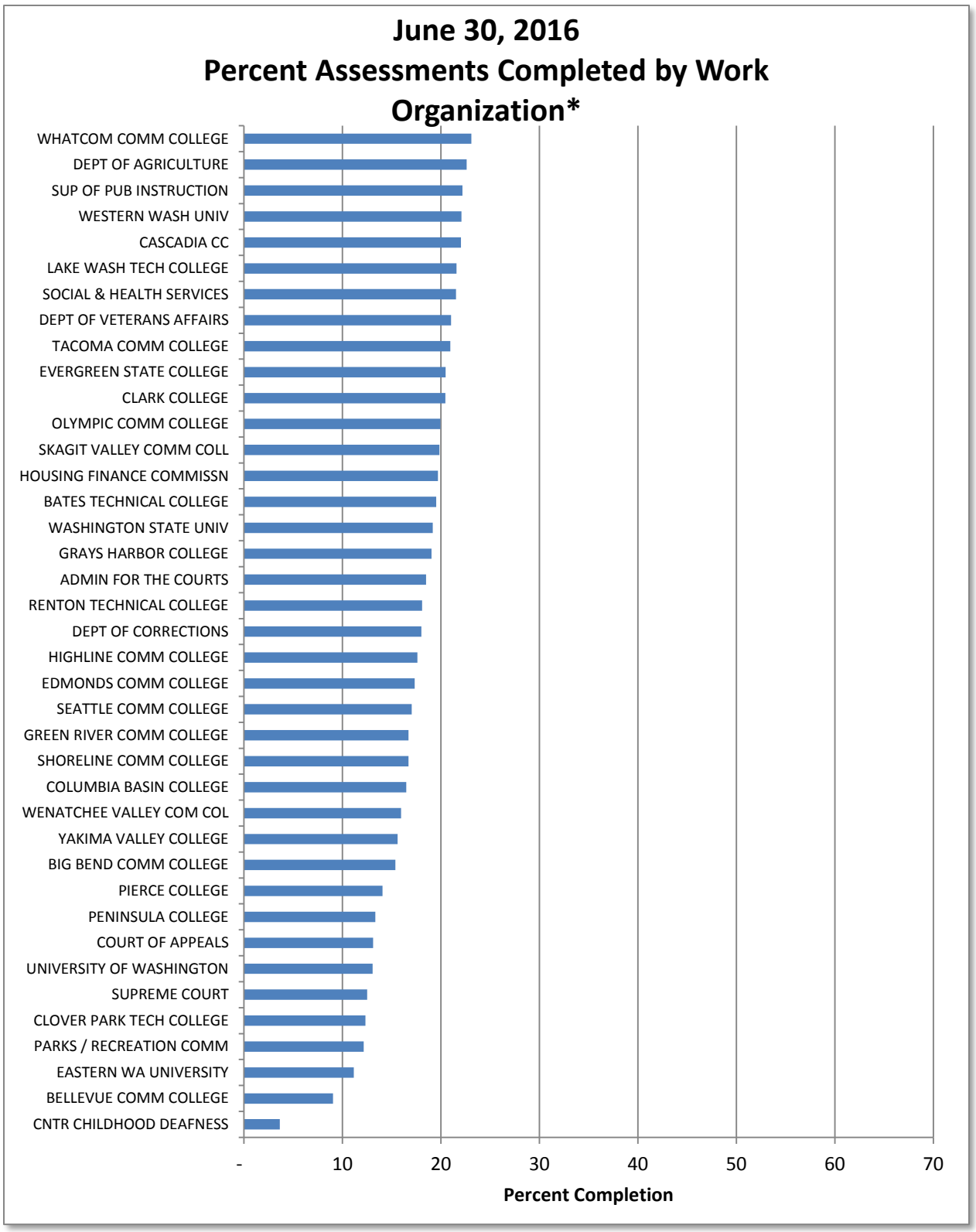

FIGURE 23: PARTICIPATION BY AGENCY, DETAILED – 2ND QUARTER 2016 (PART TWO)